Note that this document includes all recommendations currently being reviewed and workshopped by this Subcommittee, and not all will be presented to the full SURG for inclusion in the next Annual Report.

The information in this document may include content originally submitted by the member who introduced the recommendation, subsequent revisions to that recommendation, and input provided by subject matter experts during or between SURG and Subcommittee meetings.

## Recommendation #1

**Updated at March 24, 2026 Subcommittee meeting to**

***A retrospective assessment or/ and prospective study would be conducted to assess the outcomes of all patients following discharge from certified withdrawal management facilities within five years of discharge, including trends in the patterns of step down and use of MOUD, to examine potential contributors to overdose and develop best practices for continued care after treatment.***

### Submission Details

- Submitted by Chelsea Cheatom on 8/20/2025; co-sponsored by Stephanie Cook on 11/18/25

### Justification/Background

Previous studies (Strang J, McCambridge J, Best D, Beswick T, Bearn J, Rees S et al. Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study; https://doi.org/10.1136/bmj.326.7396.959) have shown that treatment reduces mortality but sometimes increases in mortality are seen when tolerance is reduced and people return to opiate misuse (relapse). This study, either prospective or retrospective, can be used to examine mortality and relapse after opioid detoxification to develop best practices for continued care after treatment within the state. Previous studies have found reduced mortality when individuals received MOUD and or residential treatment.

### Associated Research/Links

1) Strang J, McCambridge J, Best D, Beswick T, Bearn J, Rees S et al. Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study. BMJ 2003; 326:959 doi:10.1136/bmj.326.7396.959

2) Walley, A. Y., Lodi, S., Li, Y., Bernson, D., Babakhanlou-Chase, H., Land, T., & Larochelle, M. R. (2020). Association between mortality rates and medication and residential treatment after in-patient medically managed opioid withdrawal: A cohort analysis. Addiction, 115(8), 1496-1508. doi: 10.1111/add.14964. https://pubmed.ncbi.nlm.nih.gov/32096908/ which showed that mortality risk was reduced in individuals who received medication treatment (0.81 all-cause deaths & 0.52 opioid-related deaths per 100 person years), residential treatment (1.27 all-cause & 1.06 opioid-related deaths per 100 person years), or a combination of the two (fewer than 1.23 all-cause and opioid-related deaths per 100 person years), relative to those who did not receive treatment (2.04 all-cause deaths & 1.42 opioid-related deaths per 100 person years) within the 12 months following detoxification.

3) Foglia, R., Kline, A., & Cooperman, N. A. (2021). New and Emerging Opioid Overdose Risk Factors. Current addiction reports, 8(2), 319–329. https://pubmed.ncbi.nlm.nih.gov/33907663/

4) Williams A. R. (2022). Commentary on Burns et al: MOUD saves lives, especially after 60 days, and the longer the better. Addiction (Abingdon, England), 117(12), 3089–3090. https://doi.org/10.1111/add.16043

5) Heimer R., Black, A., Hsiuju, L., et al (2024). Receipt of opioid use disorder treatments prior to fatal overdoses and comparison to no treatment in Connecticut, 2016–17. Drug Alcohol Depend. 1:254:111040. https://pubmed.ncbi.nlm.nih.gov/38043226/

### AB374 Section 10 Requirement(s) Assigned to the Treatment and Recovery Subcommittee and Align with this Recommendation

(c) Assess and evaluate existing pathways to treatment and recovery for persons with substance use disorders, including, without limitation, such persons who are members of special populations.

,

(e) Evaluate ways to improve and expand evidence-based or evidence-informed

programs, procedures and strategies to treat and support recovery from opioid use disorder and any co-occurring substance use disorder, including, without limitation, among members of special populations.

,

(f) Examine support systems and programs for persons who are in recovery from opioid use disorder and any co-occurring substance use disorder.

### AB374 Section 10 Requirement(s) that are Cross-Cutting and Align with this Recommendation

(b) Assess evidence-based strategies for preventing substance use and intervening to stop substance use, including, without limitation, the use of heroin, other synthetic and non-synthetic opioids and stimulants. Such strategies must include, without limitation, strategies to:

(1)Help persons at risk of a substance use disorder avoid developing a substance use disorder;

(2)Discover potentially problematic substance use in a person and intervene before the person develops a substance use disorder;

(3)Treat the medical consequences of a substance use disorder in a person and facilitate the treatment of the substance use disorder to minimize further harm; and

(4)Reduce the harm caused by substance use, including, without limitation, by preventing overdoses.

,

(c) Assess and evaluate existing pathways to treatment and recovery for persons with substance use disorders, including, without limitation, such persons who are members of special populations.

,

(h) Examine qualitative and quantitative data to understand the risk factors that contribute to substance use and the rates of substance use and substance use disorders, focusing on special populations.

,

(q) Study, evaluate and make recommendations to the Department of Health and Human Services concerning the use of the money described in section 10.5 of this act to address substance use disorders, with a focus on:

(1) The use of the money described in subsections 1, 2 and 3 of section 10.5 of this act to supplement rather than supplant existing state or local spending;

(2) The use of the money described in section 10.5 of this act to support programs that use evidence-based interventions;

(3) The use of the money described in section 10.5 of this act to support programs for the prevention of substance use disorders in youth;

(4) The use of the money described in section 10.5 of this act to improve racial equity; and

(5) Reporting by state and local agencies to the public concerning the funding of programs to address substance misuse and substance use disorders.

**Focus Population(s)**

g. Other populations disproportionately impacted by substance use disorders

**Action Steps**

- DHHS Policy

**Short-Term or Long-Term**

- Short-term (Under 2 years)

**Fiscal Note Requirement**

- Unsure

**Impact of Recommendation *(on a scale of 1-3)***

- 2 - This recommendation could expand requirements for service referrals after a patient completes treatment

**Urgency of Recommendation *(on a scale of 1-3)***

- 1 - This is a study, so it is not urgent

**Capacity & Feasibility of Recommendation *(on a scale of 1-3)***

- 3 - Data is currently available that could be reviewed

**Advances Racial and Health Equity due to Recommendation *(on a scale of 1-3)***

- 3 - This recommendation could help with best practices for referring patients following detoxification

**Possible Presenters on this Recommendation**

- Possibly: John Hamilton with Liberation Programs, Inc. who presented on this at the RX Summit. *(presented at June 17, 2025 Subcommittee meeting)*

## Recommendation #2

**Updated at the March 24, 2026 Subcommittee meeting to**

***Recommend to the Nevada Department of Human Services that they incentivize the implementation of cohesive addiction consult services.***

***Hospitals would receive Department funds to hire peer recovery specialists, if they meet the following specific criteria: adoption of delineation of privileges for addiction medicine as a medical specialty, as well as established protocols for the inclusion of midlevel providers and peer recovery navigators.***

The updated recommendation above combines one originally submitted by Steve Shell on 6/17/25 and one submitted by Jose Maria Partida Corona, MD, FASAM on 3/23/2026. The back-up and justification for each are presented below. Steve Shell's justification is presented first, followed by the justification information presented by Dr. Partida Corona.

### Submission Details

- Submitted by Steve Shell on 6/17/2025

### Justification/Background

Hospital emergency rooms continue to struggle with a high volume of patients who present with substance misuse and often with co-occurring mental health conditions. A high percentage of these individuals have multiple visits to the ERs for various reasons that are associated with their substance misuse. The ER teams do their best to evaluate, treat and connect to community services, but many of their team members lack the expertise to effectively manage substance misuse and do not have lived experience like peer recovery support specialists. Evidence has shown that connecting individuals with substance misuse to a peer while in the ER leads to better outcomes as the peer can help navigate a transfer to treatment options in the community as well as maintain communication with the individual for a period of time to encourage recovery. Hospitals would be more motivated to establish peer support teams if financial assistance is provided on a long-term basis.

### Associated Research/Links

- Doran KM, Welch AE, Kepler KL, et al. Peer Navigator Intervention and Opioid-Related Adverse Events for Emergency Department Patients: A Randomized Clinical Trial. *JAMA Netw Open.* 2026;9(2):e2555903. doi:10.1001/jamanetworkopen.2025.55903. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2844716
- Weiner SG, Hawk KF. The Role of Peer Navigators After Nonfatal Opioid Overdose—Context, Evidence, and Future Directions. *JAMA Netw Open.* 2026;9(2):e2555780. doi:10.1001/jamanetworkopen.2025.55780 https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2844720

### AB374 Section 10 Requirement(s) Assigned to the Treatment and Recovery Subcommittee and Align with this Recommendation

(f) Examine support systems and programs for persons who are in recovery from opioid use disorder and any co-occurring substance use disorder.

### AB374 Section 10 Requirement(s) that are Cross-Cutting and Align with this Recommendation

(b) Assess evidence-based strategies for preventing substance use and intervening to stop substance use, including, without limitation, the use of heroin, other synthetic and non-synthetic opioids and stimulants. Such strategies must include, without limitation, strategies to:

(1 )Help persons at risk of a substance use disorder avoid developing a substance use disorder;

(2) Discover potentially problematic substance use in a person and intervene before the person develops a substance use disorder;

(3) Treat the medical consequences of a substance use disorder in a person and facilitate the treatment of the substance use disorder to minimize further harm; and

(4) Reduce the harm caused by substance use, including, without limitation, by preventing overdoses.

,

(c) Assess and evaluate existing pathways to treatment and recovery for persons

,

(q) Study, evaluate and make recommendations to the Department of Health and Human Services concerning the use of the money described in section 10.5 of this act to address substance use disorders, with a focus on:

(1) The use of the money described in subsections 1, 2 and 3 of section 10.5 of this act to supplement rather than supplant existing state or local spending;

(2) The use of the money described in section 10.5 of this act to support programs that use evidence-based interventions;

(3) The use of the money described in section 10.5 of this act to support programs for the prevention of substance use disorders in youth;

(4) The use of the money described in section 10.5 of this act to improve racial equity; and

(5) Reporting by state and local agencies to the public concerning the funding of programs to address substance misuse and substance use disorders.

### Focus Population(s)

My recommendation does not focus on a special population

### Action Steps

- Expenditure of Opioid Settlement Funds

### Short-Term or Long-Term

- Long-term (2+ years)

### Fiscal Note Requirement

- Unsure

### Impact of Recommendation *(on a scale of 1-3)*

- 3 - Due to the high volume of patients with substance misuse in hospital emergency rooms around Nevada, establishing peer support teams is the most efficient way to address these individuals to get them connected to community resources as quickly as possible

**Urgency of Recommendation *(on a scale of 1-3)***

- 3 - Due to the high volume of patients with substance misuse in hospital emergency rooms around Nevada, it is imperative that we act quickly to establish peer support teams that are extremely effective to connect individuals to treatment and guide them on their path to recovery

**Capacity & Feasibility of Recommendation *(on a scale of 1-3)***

- 3 - Due to CASAT's phenomenal certification program for peer recovery support specialists, there are many peers around Nevada who can be hired by hospitals to work in emergency rooms

**Advances Racial and Health Equity due to Recommendation *(on a scale of 1-3)***

- 2 - None provided

**Possible Presenters on this Recommendation**

- Sean Hampton with Foundation For Recovery
- A representative from CASAT

**Submission Details**

- Submitted by Jose Maria Partida Corona, MD, FASAM on 3/23/2026

**Justification/Background**

The establishment of delineation of privileges for addiction specialists will allow them to be recognized as a specialty within the hospital, such as cardiologists or neurologists are currently. This allows a pathway for insurances to reimburse for their services as specialists, rather than having their services go unreimbursed. Also, by establishing a clear pathway for midlevels to provide supervised assistance to these specialists, as well as peer recovery navigators, we create the environment for a much more robust level of care for both patients that will be hospitalized for further care, as well as patients that will be discharged from the ER.

**Associated Research/Links**

- Englander, H., Dobbertin, K., Lind, B.K. et al. Inpatient Addiction Medicine Consultation and Post-Hospital Substance Use Disorder Treatment Engagement: a Propensity-Matched Analysis. J GEN INTERN MED 34, 2796–2803 (2019). https://doi.org/10.1007/s11606-019-05251-9

**AB374 Section 10 Requirement(s) Assigned to the Treatment and Recovery Subcommittee and Align with this Recommendation**

(c) Assess and evaluate existing pathways to treatment and recovery for persons with substance use disorders, including, without limitation, such persons who are members of special populations.

(e) Evaluate ways to improve and expand evidence-based or evidence-informed programs, procedures and strategies to treat and support recovery from opioid use disorder and any co-occurring substance use disorder, including, without limitation, among members of special populations.

(f)Examine support systems and programs for persons who are in recovery from opioid use disorder and any co-occurring substance use disorder.

**AB374 Section 10 Requirement(s) that are Cross-Cutting and Align with this Recommendation**

(c) Assess and evaluate existing pathways to treatment and recovery for persons with substance use disorders, including, without limitation, such persons who are members of special populations.

(h) Examine qualitative and quantitative data to understand the risk factors that contribute to substance use and the rates of substance use and substance use disorders, focusing on special populations.

(q) Study, evaluate and make recommendations to the Department of Health and Human Services concerning the use of the money described in section 10.5 of this act to address substance use disorders, with a focus on:

(1) The use of the money described in subsections 1, 2 and 3 of section 10.5 of this act to supplement rather than supplant existing state or local spending;
(2) The use of the money described in section 10.5 of this act to support programs that use evidence-based interventions;
(3) The use of the money described in section 10.5 of this act to support programs for the prevention of substance use disorders in youth;
(4) The use of the money described in section 10.5 of this act to improve racial equity; and
(5) Reporting by state and local agencies to the public concerning the funding of programs to address substance misuse and substance use disorders.

**Focus Population(s)**

My recommendation does not focus on a special population.

**Action Steps**

- Expenditure of Opioid Settlement Funds
- DHHS Policy
- Requiring hospitals meet these goals in order to be eligible for Opioid Settlement Funds

**Short-Term or Long-Term**

- Long- term (2+ years)

**Fiscal Note Requirement**

- Unsure

**Impact of Recommendation *(on a scale of 1-3)***

- 3 - Highly impactful, by opening the door to the creation of addiction treatment services in the hospital setting, as well as creating a much better system for warm hand off to outpatient treatment from the ER.

**Urgency of Recommendation *(on a scale of 1-3)***

- 3 - It will take time to implement such regulatory changes in hospital policies and procedures, so the sooner this is initiated, the better.

**Capacity & Feasibility of Recommendation *(on a scale of 1-3)***

- 2 - There are already models to work from both in the Las Vegas community and readily available from ASAM or NVSAM.

**Advances Racial and Health Equity due to Recommendation *(on a scale of 1-3)***

- 2 - It will provide greater access to addiction specialists to underserved populations, as they tend to use the ER and hospitals more readily than the outpatient setting given limitations of insurance coverage.

**Possible Presenters on this Recommendation**

- Dr Brian Kaszuba
- Dr Maureen Strohm

# Recommendation #3

**Updated at March 24, 2026 Subcommittee meeting to**

***Recommend that state funding be increased for Contingency Management, to be used to support people in recovery through rewards for reaching their recovery goals.***

### Submission Details

- Submitted by Chelsea Cheatom on 9/25/2025; co-sponsored by Guiseppe Mandel on 3/24/26

### Justification/Background

Contingency management has been a strategy used to reward people for treatment and recovery goals. While there may be funding in the state to support contingency management, it is not currently covered by Medicaid (as far as I know). Additional support could help to support more treatment providers to incentivize patients reaching their treatment goals

### Associated Research/Links

- https://cherishresearch.org/news-and-events/news/incentivizing-recovery-payment-policy-and-implementation-of-contingency-management/
- https://pmc.ncbi.nlm.nih.gov/articles/PMC9045772/
- https://library.samhsa.gov/sites/default/files/contingency-management-advisory-pep24-06-001.pdf

### AB374 Section 10 Requirement(s) Assigned to the Treatment and Recovery Subcommittee and Align with this Recommendation

(e) Evaluate ways to improve and expand evidence-based or evidence-informed programs, procedures and strategies to treat and support recovery from opioid use disorder and any co-occurring substance use disorder, including, without limitation, among members of special populations.

(f) Examine support systems and programs for persons who are in recovery from opioid use disorder and any co-occurring substance use disorder.

### AB374 Section 10 Requirement(s) that are Cross-Cutting and Align with this Recommendation

(b)Assess evidence-based strategies for preventing substance use and intervening to stop substance use, including, without limitation, the use of heroin, other synthetic and non-synthetic opioids and stimulants. Such strategies must include, without limitation, strategies to:

(1) Help persons at risk of a substance use disorder avoid developing a substance use disorder;

(2) Discover potentially problematic substance use in a person and intervene before the person develops a substance use disorder;

(3) Treat the medical consequences of a substance use disorder in a person and facilitate the treatment of the substance use disorder to minimize further harm; and

(4) Reduce the harm caused by substance use, including, without limitation, by preventing overdoses.

(q) Study, evaluate and make recommendations to the Department of Health and Human Services concerning the use of the money described in section 10.5 of this act to address substance use disorders, with a focus on:

(1) The use of the money described in subsections 1, 2 and 3 of section 10.5 of this act to supplement

rather than supplant existing state or local spending;
(2) The use of the money described in section 10.5 of this act to support programs that use evidence-based interventions;
(3) The use of the money described in section 10.5 of this act to support programs for the prevention of substance use disorders in youth;
(4) The use of the money described in section 10.5 of this act to improve racial equity; and
(5) Reporting by state and local agencies to the public concerning the funding of programs to address substance misuse and substance use disorders.

**Focus Population(s)**

My recommendation does not focus on a special population.

**Action Steps**

- Bill Draft Request (BDR)
- Expenditure of Opioid Settlement Funds
- DHHS Policy

**Short-Term or Long-Term**

- Long-term (2+ years)

**Fiscal Note Requirement**

- Unsure

**Impact of Recommendation *(on a scale of 1-3)***

- 2 - People in treatment and recovery can gain financial supports to help them stay in recovery

**Urgency of Recommendation *(on a scale of 1-3)***

- 1 - N/A

**Capacity & Feasibility of Recommendation *(on a scale of 1-3)***

- 2 - We believe that SNHD is supporting this effort currently (perhaps Jessica Johnson could provide detail) and some providers are supporting contingency management in a smaller scale

**Advances Racial and Health Equity due to Recommendation *(on a scale of 1-3)***

- 2 - This will help to support people in treatment financially

**Possible Presenters on this Recommendation**

- One of the researchers from the studies attached, Jessica Johnson from SNHD, may have suggestions. I believe that Partida Corona Medical Center may be supporting this effort already

*(CASAT presented on this recommendation at the March 24, 2026 Subcommittee meeting)*

# Recommendation #4

**Updated at March 24, 2026 Subcommittee meeting to**

***Elimination of prior authorizations needed for starting medication assisted therapy with buprenorphine and buprenorphine products of all types for opioid use disorder. This would apply to all payors including Medicaid MCOs (Managed Care Organizations).***

### Submission Details

- Submitted by Jose Maria Partida Corona, MD, FASAM on 3/22/2026

### Justification/Background

Prior authorizations present an unnecessary delay in initiation of treatment for opioid use disorder. In the era of fentanyl, this can be a particularly dangerous delay of care, as it can often result in a patient relapsing and dying of an unintended overdose while waiting for the medication to be approved. All of which can be avoided by eliminating the barrier that is prior authorization. The best way is to mandate coverage for any and all buprenorphine products when being used to initiate treatment for opioid use disorder by any insurance, but specifically Nevada Medicaid and all Medicaid products including MCOs, as well as Medicare. As it is, no prior authorization is required to initiate Sublocade or Brixadi, which are injectable versions of buprenorphine and which are the most costly options for treatment, so this change will, in fact, generate savings for Medicaid, as less expensive, but equally effective options may be exercised readily.

### Associated Research/Links

- Ferries E, Racsa P, Bizzell B, Rhodes C, Suehs B. Removal of prior authorization for medication-assisted treatment: impact on opioid use and policy implications in a Medicare Advantage population. J Manag Care Spec Pharm. 2021 May;27(5):596-606. doi: 10.18553/jmcp.2021.27.5.596. PMID: 33908274; PMCID: PMC10390915.

### AB374 Section 10 Requirement(s) Assigned to the Treatment and Recovery Subcommittee and Align with this Recommendation

(c) Assess and evaluate existing pathways to treatment and recovery for persons with substance use disorders, including, without limitation, such persons who are members of special populations.

(e) Evaluate ways to improve and expand evidence-based or evidence-informed programs, procedures and strategies to treat and support recovery from opioid use disorder and any co-occurring substance use disorder, including, without limitation, among members of special populations.

### AB374 Section 10 Requirement(s) that are Cross-Cutting and Align with this Recommendation

(b) Assess evidence-based strategies for preventing substance use and intervening to stop substance use, including, without limitation, the use of heroin, other synthetic and non-synthetic opioids and stimulants. Such strategies must include, without limitation, strategies to:

(1) Help persons at risk of a substance use disorder avoid developing a substance use disorder;

(2) Discover potentially problematic substance use in a person and intervene before the person develops a substance use disorder;

(3) Treat the medical consequences of a substance use disorder in a person and facilitate the treatment of the substance use disorder to minimize further harm; and

(4) Reduce the harm caused by substance use, including, without limitation, by preventing overdoses.

(c) Assess and evaluate existing pathways to treatment and recovery for persons with substance use disorders, including, without limitation, such persons who are members of special populations.

### Focus Population(s)

My recommendation does not focus on a special population.

### Action Steps

- DHHS Policy
- Change Medicaid policy to eliminate prior authorizations for buprenorphine products of all kinds.

### Short-Term or Long-Term

- Long-term (2+ years)

### Fiscal Note Requirement

- No fiscal note

### Impact of Recommendation *(on a scale of 1-3)*

- 3 - It will help prevent delay of care for patients that are actively seeking treatment for opioid use disorder by allowing them access to lifesaving medications in a timely fashion.

### Urgency of Recommendation *(on a scale of 1-3)*

- 3 - These are unforced errors that our medical system creates CURRENTLY and on a daily basis.

### Capacity & Feasibility of Recommendation *(on a scale of 1-3)*

- 3 - It would really only require Medicaid to change its policy and ban prior authorizations in this, very specific, situation.

### Advances Racial and Health Equity due to Recommendation *(on a scale of 1-3)*

- 3 - It would allow much better access to treatment for opioid use disorder, regardless of the patient's current insurance. This would lead to better health equity between those that are privately insured and those that are insured by Medicaid.

### Possible Presenters on this Recommendation

- Dr George Kaiser
- Dr Maureen Strohm
- Dr Stephanie Zority
- Dr Brian Kaszuba
- Kate Jessop

# Recommendation #5

**Updated at March 24, 2026 Subcommittee meeting to**

***Recommend that insurers and payors not impose dosage limitations for buprenorphine when used for Medications for Opioid use Disorder (MOUD).***

### Submission Details

- Submitted by Jose Maria Partida Corona, MD, FASAM on 3/23/2026

### Justification/Background

Placement of limitations on buprenorphine dosages is actually counterproductive in several ways. First, by placing restrictions on dosing, it engenders in the minds of physicians a mindset that buprenorphine is a dangerous medication that could easily lead to overdose. This could not be further from the truth. It actually serves to protect from overdose. Second, it stigmatizes patients that are trying to stay in compliance and treatment for their opioid use disorder. Third, it creates a barrier to trust between physician and patient, by introducing limitations from a third party, which is highly problematic when treating a stigmatized population. Fourth, it interjects a limitation to treatment that is not based on best practices, but that is, in fact, rooted in institutional stigmatization of a patient population.

### Associated Research/Links


- NIDA. 2023, September 18. Higher buprenorphine doses associated with improved retention in treatment for opioid use disorder. Retrieved from https://nida.nih.gov/news-events/news-releases/2023/09/higher-buprenorphine-doses-associated-with-improved-retention-in-treatment-for-opioid-use-disorder on 2026, March 18
- NNT Group. (n.d.). *Buprenorphine maintenance vs. placebo for opioid dependence*. The NNT. Retrieved March 22, 2026, from [https://thennt.com/nnt/buprenorphine-maintenance-vs-placebo-opioid-dependence/](https://thennt.com/nnt/buprenorphine-maintenance-vs-placebo-opioid-dependence/)


### AB374 Section 10 Requirement(s) Assigned to the Treatment and Recovery Subcommittee and Align with this Recommendation

(e) Evaluate ways to improve and expand evidence-based or evidence-informed programs, procedures and strategies to treat and support recovery from opioid use disorder and any co-occurring substance use disorder, including, without limitation, among members of special populations.

### AB374 Section 10 Requirement(s) that are Cross-Cutting and Align with this Recommendation

(c) Assess and evaluate existing pathways to treatment and recovery for persons with substance use disorders, including, without limitation, such persons who are members of special populations.
(h) Examine qualitative and quantitative data to understand the risk factors that contribute to substance use and the rates of substance use and substance use disorders, focusing on special populations.
(q) Study, evaluate and make recommendations to the Department of Health and Human Services concerning the use of the money described in section 10.5 of this act to address substance use disorders, with a focus on:

(1) The use of the money described in subsections 1, 2 and 3 of section 10.5 of this act to supplement rather than supplant existing state or local spending;

(2) The use of the money described in section 10.5 of this act to support programs that use evidence-based interventions;
(3) The use of the money described in section 10.5 of this act to support programs for the prevention of substance use disorders in youth;
(4) The use of the money described in section 10.5 of this act to improve racial equity; and
(5) Reporting by state and local agencies to the public concerning the funding of programs to address substance misuse and substance use disorders.

**Focus Population(s)**

My recommendation does not focus on a special population.

**Action Steps**

- DHHS Policy

**Short-Term or Long-Term**

- Long- term (2+ years)

**Fiscal Note Requirement**

- Unsure

**Impact of Recommendation *(on a scale of 1-3)***

- 3 - It will increase the success of medication assisted treatment when it is allowed to happen.

**Urgency of Recommendation *(on a scale of 1-3)***

- 3 - The sooner we make this change, the less barriers will exist for patients currently seeking treatment for fentanyl dependency or use disorder.

**Capacity & Feasibility of Recommendation *(on a scale of 1-3)***

- 3 - It will only require a change in Medicaid policy.

**Advances Racial and Health Equity due to Recommendation *(on a scale of 1-3)***

- 3 - It will help patients on higher doses of fentanyl, which is more common among the unhoused, a group that generally gets less regular healthcare and less treatment for substance use disorders.

**Possible Presenters on this Recommendation**

- Dr George Kaiser
- Dr Maureen Strohm
- Kate Jessop, NP- Inaugural provider for CCDC MAT program

# Recommendation #6

***When medication assisted treatment is initiated in detox, we should recommend continuance of medication assisted treatment for the duration of detox, inpatient treatment, IOP and for one year from time of initiation***

### Submission Details

- Submitted by Jose Maria Partida Corona, MD, FASAM on 3/23/2026

### Justification/Background

Although it is common practice for patients to be taken off medication assisted treatment straight from detox, there is plenty of evidence showing patients fare better when medication assisted treatment is continued, particularly when treated for one year or longer. Of note, it is common practice in lower acuity care, such as ASAM criteria level one care, to treat patients with medication assisted treatment for months, if not years with said medications. It does not make clinical sense then, to taper patients off medication assisted treatment straight from detox, resulting in much more relapse and repeat admission to inpatient care.

### Associated Research/Links


- Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database Syst Rev. 2014;(2):CD002207.
- Glanz JM, Binswanger IA, Clarke CL, Nguyen AP, Ford MA, Ray GT, Xu S, Hechter RC, Yarborough BJH, Roblin DW, Ahmedani B, Boscarino JA, Andrade SE, Rosa CL, Campbell CI. The association between buprenorphine treatment duration and mortality: a multi-site cohort study of people who discontinued treatment. Addiction. 2023 Jan;118(1):97-107. doi: 10.1111/add.15998. Epub 2022 Jul 23. PMID: 35815386; PMCID: PMC9722535. https://pubmed.ncbi.nlm.nih.gov/35815386/


### AB374 Section 10 Requirement(s) Assigned to the Treatment and Recovery Subcommittee and Align with this Recommendation

(e) Evaluate ways to improve and expand evidence-based or evidence-informed programs, procedures and strategies to treat and support recovery from opioid use disorder and any co-occurring substance use disorder, including, without limitation, among members of special populations.

### AB374 Section 10 Requirement(s) that are Cross-Cutting and Align with this Recommendation

(c) Assess and evaluate existing pathways to treatment and recovery for persons with substance use disorders, including, without limitation, such persons who are members of special populations.

(h) Examine qualitative and quantitative data to understand the risk factors that contribute to substance use and the rates of substance use and substance use disorders, focusing on special populations.

### Focus Population(s)

My recommendation does not focus on a special population.

### Action Steps

- We could make it a regular point of auditing when recertification takes place.

**Short-Term or Long-Term**

- Long- term (2+ years)

**Fiscal Note Requirement**

- Unsure

**Impact of Recommendation *(on a scale of 1-3)***

- 3 - It will result in much less readmission to higher levels of care upon release from inpatient treatment.

**Urgency of Recommendation *(on a scale of 1-3)***

- 2 - These patients are already receiving treatment, but the treatment currently isn't evidence based. 2

**Capacity & Feasibility of Recommendation *(on a scale of 1-3)***

- 2 - It will take some changes in our regulatory structure to make sure this is being followed.

**Advances Racial and Health Equity due to Recommendation *(on a scale of 1-3)***

- 1 - Not clear if it provides better care for underrepresented groups, as they tend not to be receiving as much inpatient care, but it still raises the bar and the expectation for MAT to be more mainstream in care.

**Possible Presenters on this Recommendation**

- Dr George Kaiser- Westcare

# Recommendation #7

***Nevada prescription monitoring program should include methadone dosing from any substance use treatment facility, including methadone clinics. Or, Nevada needs to adopt a methadone central registry.***

### Submission Details

- Submitted by Jose Maria Partida Corona, MD, FASAM on 3/23/2026

### Justification/Background

Many patients receiving methadone treatment can become hospitalized or incarcerated. During these hospitalizations and incarcerations, there is often great difficulty in obtaining accurate information regarding a patient's true, current, methadone dose. If these were reported into Nevada Prescription Monitoring Program, it would prevent underdosing or overdosing patients on medication assisted treatment and make for much easier calculations for pain management, should the need arise.

### Associated Research/Links

- Marks KR, Talbert J, Hammerslag LR, Lofwall MR, Fanucchi LC, Broce H, Walsh SL. Contributions of a central registry to monitor methadone -treatment through the HEALing Communities Study. J Opioid Manag. 2023 Oct 18;19(7 (Spec Issue)):73-81. doi: 10.5055/jom.2023.0801. PMID: 37879662; PMCID: PMC11934856. https://pmc.ncbi.nlm.nih.gov/articles/PMC11934856/

### AB374 Section 10 Requirement(s) Assigned to the Treatment and Recovery Subcommittee and Align with this Recommendation

(e) Evaluate ways to improve and expand evidence-based or evidence-informed programs, procedures and strategies to treat and support recovery from opioid use disorder and any co-occurring substance use disorder, including, without limitation, among members of special populations.

(f)Examine support systems and programs for persons who are in recovery from opioid use disorder and any co-occurring substance use disorder.

### AB374 Section 10 Requirement(s) that are Cross-Cutting and Align with this Recommendation

(c) Assess and evaluate existing pathways to treatment and recovery for persons with substance use disorders, including, without limitation, such persons who are members of special populations.

(q) Study, evaluate and make recommendations to the Department of Health and Human Services concerning the use of the money described in section 10.5 of this act to address substance use disorders, with a focus on:

(1) The use of the money described in subsections 1, 2 and 3 of section 10.5 of this act to supplement rather than supplant existing state or local spending;
(2) The use of the money described in section 10.5 of this act to support programs that use evidence-based interventions;
(3) The use of the money described in section 10.5 of this act to support programs for the prevention of substance use disorders in youth;
(4) The use of the money described in section 10.5 of this act to improve racial equity; and
(5) Reporting by state and local agencies to the public concerning the funding of programs to address substance misuse and substance use disorders.

**Focus Population(s)**

b. Persons who are incarcerated, persons who have committed nonviolent crimes primarily driven by a substance use disorder and other persons involved in the criminal justice or juvenile systems

g. Other populations disproportionately impacted by substance use disorders

**Action Steps**

- Bill Draft Request (BDR)
- Expenditure of Opioid Settlement Funds
- DHHS Policy

**Short-Term or Long-Term**

- Long- term (2+ years)

**Fiscal Note Requirement**

- Unsure

**Impact of Recommendation *(on a scale of 1-3)***

- 2 - It should help those incarcerated and those receiving care during hospitalization who are currently enrolled in MAT with methadone.

**Urgency of Recommendation *(on a scale of 1-3)***

- 2 - It could lead to better care and help avoid unnecessary complications from lack of information for providers treating patients with SUD.

**Capacity & Feasibility of Recommendation *(on a scale of 1-3)***

- 2 - It would have to involve either establishing a methadone central registry to be created, or better yet, addition of reporting from methadone clinics to the NV PMP program for monitoring.

**Advances Racial and Health Equity due to Recommendation *(on a scale of 1-3)***

- 2 - It would provide better care for those on methadone, which are disproportionately people of lower socioeconomic backgrounds.

**Possible Presenters on this Recommendation**

- Dr George Kaiser
- Dr Maureen Strohm
- Dr Lesley Dickson

## Recommendation #8

***Hospital ERs should have a daily call schedule for outpatient follow up regarding substance use disorders, just like what currently exists for primary care. This list can be derived from NVSAM, SNAAP and SAMSHA collaboration which will produce a master list to the hospitals throughout the state. It will not be the hospital's responsibility to create the list, only to dispense it to the appropriate patients.***

### Submission Details

- Submitted by Jose Maria Partida Corona, MD, FASAM on 3/23/2026

### Justification/Background

The establishment of a list with robust information, such as insurances taken, medications provided, services provided, etc, would provide a greater likelihood of patients seeking treatment for their substance use disorders in the ER actually getting long term care for said affliction.

### Associated Research/Links

- Krawczyk N, Rivera BD, Chang JE, Grivel M, Chen YH, Nagappala S, Englander H, McNeely J. Strategies to support substance use disorder care transitions from acute-care to community-based settings: A Scoping review and typology. medRxiv [Preprint]. 2023 Jun 25:2023.04.24.23289042. doi: 10.1101/2023.04.24.23289042. Update in: Addict Sci Clin Pract. 2023 Nov 2;18(1):67. doi: 10.1186/s13722-023-00422-w. PMID: 37162840; PMCID: PMC10168484. https://pmc.ncbi.nlm.nih.gov/articles/PMC10168484/

### AB374 Section 10 Requirement(s) Assigned to the Treatment and Recovery Subcommittee and Align with this Recommendation

(e) Evaluate ways to improve and expand evidence-based or evidence-informed programs, procedures and strategies to treat and support recovery from opioid use disorder and any co-occurring substance use disorder, including, without limitation, among members of special populations.

### AB374 Section 10 Requirement(s) that are Cross-Cutting and Align with this Recommendation

(c) Assess and evaluate existing pathways to treatment and recovery for persons with substance use disorders, including, without limitation, such persons who are members of special populations.

### Focus Population(s)

My recommendation does not focus on a special population.

### Action Steps

- Expenditure of Opioid Settlement Funds

### Short-Term or Long-Term

- Long- term (2+ years)

### Fiscal Note Requirement

- Estimated fiscal note amount: Probably about $20,000 yearly to organize, maintain and implement list of providers to serve on a call list.

**Impact of Recommendation *(on a scale of 1-3)***

- 2 - It will provide ERs with an invaluable, current list of resources in the community that is better tailored to the specific information needed by the patient, including insurances taken, medications and services provided, so that they can receive a more curated referral that applies best to the patient's unique set of circumstances.

**Urgency of Recommendation *(on a scale of 1-3)***

- 2 - The sooner such a system is implemented, the sooner patients in the ER get more accurately referred to outpatient care for their SUD.

**Capacity & Feasibility of Recommendation *(on a scale of 1-3)***

- 2 - Although we have the beginning database for this, further work would have to be done to put together better detail regarding services and medications provided, as well as insurances taken.

**Advances Racial and Health Equity due to Recommendation *(on a scale of 1-3)***

- 2 - It would give better guidance to care that takes a particular patient's insurance, which is very useful and timely information given the rapidity most patients with SUD wish to enter care when they have decided to take a step towards recovery.

**Possible Presenters on this Recommendation**

- Dr Kelly Morgan

## Recommendation #9

***7) A research study should be funded and conducted to investigate the cost savings associated with early intervention for care via street medicine for the unhoused. The goal of such a study is to elucidate the viability of shared savings payment models to facility third party payer support for such street medicine teams, rather than support through grant funding, which is inherently unstable.***

### Submission Details

- Submitted by Jose Maria Partida Corona, MD, FASAM on 3/23/2026

### Justification/Background

Street medicine is the most effective means to address medical issues among the unhoused prior to these medical issues requiring costly hospitalization. By providing proof of savings generated by this approach, third party payers are much more likely to adopt funding of street medicine, making this approach much more renascent.

### Associated Research/Links

- Lynch KA, Harris T, Jain SH, Hochman M. The Case for Mobile "Street Medicine" for Patients Experiencing Homelessness. J Gen Intern Med. 2022 Nov;37(15):3999-4001. doi: 10.1007/s11606-022-07689-w. Epub 2022 Jun 9. PMID: 35680694; PMCID: PMC9640493. https://pmc.ncbi.nlm.nih.gov/articles/PMC9640493/ National Alliance to End Homelessness. (n.d.). Opioid abuse and homelessness. National Alliance to End Homelessness. https://endhomelessness.org/resources/policy-information/opioid-abuse-and-homelessness/

### AB374 Section 10 Requirement(s) Assigned to the Treatment and Recovery Subcommittee and Align with this Recommendation

(e) Evaluate ways to improve and expand evidence-based or evidence-informed programs, procedures and strategies to treat and support recovery from opioid use disorder and any co-occurring substance use disorder, including, without limitation, among members of special populations.

(f)Examine support systems and programs for persons who are in recovery from opioid use disorder and any co-occurring substance use disorder.

### AB374 Section 10 Requirement(s) that are Cross-Cutting and Align with this Recommendation

(b) Assess evidence-based strategies for preventing substance use and intervening to stop substance use, including, without limitation, the use of heroin, other synthetic and non-synthetic opioids and stimulants. Such strategies must include, without limitation, strategies to:

(1) Help persons at risk of a substance use disorder avoid developing a substance use disorder;
(2) Discover potentially problematic substance use in a person and intervene before the person develops a substance use disorder;
(3) Treat the medical consequences of a substance use disorder in a person and facilitate the treatment of the substance use disorder to minimize further harm; and
(4) Reduce the harm caused by substance use, including, without limitation, by preventing overdoses.

(c) Assess and evaluate existing pathways to treatment and recovery for persons with substance use disorders, including, without limitation, such persons who are members of special populations.

(h) Examine qualitative and quantitative data to understand the risk factors that contribute to substance use and the rates of substance use and substance use disorders, focusing on special populations.

(q) Study, evaluate and make recommendations to the Department of Health and Human Services concerning the use of the money described in section 10.5 of this act to address substance use disorders, with a focus on:

(1) The use of the money described in subsections 1, 2 and 3 of section 10.5 of this act to supplement rather than supplant existing state or local spending;
(2) The use of the money described in section 10.5 of this act to support programs that use evidence-based interventions;
(3) The use of the money described in section 10.5 of this act to support programs for the prevention of substance use disorders in youth;
(4) The use of the money described in section 10.5 of this act to improve racial equity; and
(5) Reporting by state and local agencies to the public concerning the funding of programs to address substance misuse and substance use disorders.

**Focus Population(s)**

a. Veterans, elderly persons and youth

b. Persons who are incarcerated, persons who have committed nonviolent crimes primarily driven by a substance use disorder and other persons involved in the criminal justice or juvenile systems

e. People who inject drugs; (as revised)

g. Other populations disproportionately impacted by substance use disorders

**Action Steps**

- Expenditure of Opioid Settlement Funds

**Short-Term or Long-Term**

- Long- term (2+ years)

**Fiscal Note Requirement**

- Unsure

**Impact of Recommendation *(on a scale of 1-3)***

- 3 - As mentioned, such research may lead to third party payers adopting the funding of street medicine/ mobile medicine teams through a cost savings model, providing these types of programs alternative revenue sources apart from the typical normal Medicaid reimbursement and grant funding.

**Urgency of Recommendation *(on a scale of 1-3)***

- 3 - Given the difficulty most non-profits are experiencing in this governmental climate to receive grant funding, such research could quite possibly be the difference between these services existing in our community or not.

**Capacity & Feasibility of Recommendation *(on a scale of 1-3)***

- 2 - This would take involving the school of public health and possibly the school of public policy at UNLV with current teams providing outreach services to the unhoused in the Las Vegas community

**Advances Racial and Health Equity due to Recommendation *(on a scale of 1-3)***

- 3 - Could not possibly be more geared to the underserved.

**Possible Presenters on this Recommendation**

- Michele Jorge- Track B
- Ron Schnese- SNAAP, The Center

# Recommendation #10

***Funding should be made available for addiction specialists to advertise outpatient ASAM criteria level one services in state, particularly if those addiction specialists are board certified, trained in Nevada or both.***

### Submission Details

- Submitted by Jose Maria Partida Corona, MD, FASAM on 3/23/2026

### Justification/Background

Although many patients cannot enter inpatient rehab because of insurance or work/family commitment limitations, these patients often still do well with treatment at a lower level of care, which is much less expensive. However, because many inpatient services also have IOP services and generate income in the tens of thousands per patient treated, they raise the average cost of advertising for all those providing addiction services. If we provide a stipend for advertising to addiction specialists committing to a certain length of stay in our community providing level one care, we can effectively build a deeper bench of addiction specialists, particularly those that are familiar with the resources that already exist in our community if they were trained in Nevada.

### Associated Research/Links

- None provided

### AB374 Section 10 Requirement(s) Assigned to the Treatment and Recovery Subcommittee and Align with this Recommendation

(e) Evaluate ways to improve and expand evidence-based or evidence-informed programs, procedures and strategies to treat and support recovery from opioid use disorder and any co-occurring substance use disorder, including, without limitation, among members of special populations.

### AB374 Section 10 Requirement(s) that are Cross-Cutting and Align with this Recommendation

(q) Study, evaluate and make recommendations to the Department of Health and Human Services concerning the use of the money described in section 10.5 of this act to address substance use disorders, with a focus on:

(1) The use of the money described in subsections 1, 2 and 3 of section 10.5 of this act to supplement rather than supplant existing state or local spending;
(2) The use of the money described in section 10.5 of this act to support programs that use evidence-based interventions;
(3) The use of the money described in section 10.5 of this act to support programs for the prevention of substance use disorders in youth;
(4) The use of the money described in section 10.5 of this act to improve racial equity; and
(5) Reporting by state and local agencies to the public concerning the funding of programs to address substance misuse and substance use disorders.

### Focus Population(s)

- My recommendation does not focus on a special population.

**Action Steps**

- Expenditure of Opioid Settlement Funds

**Short-Term or Long-Term**

- Long- term (2+ years)

**Fiscal Note Requirement**

- Estimated fiscal note amount: $20,000 per year for three years per Addiction specialist recruited.

**Impact of Recommendation *(on a scale of 1-3)***

- 3 - It would help recruit and retain addiction specialists that are board certified and most importantly, help us keep those that we have already trained within our community.

**Urgency of Recommendation *(on a scale of 1-3)***

- 2 - The sooner it is implemented, the more attractive Nevada becomes to addiction specialists to practice in. It should also considerably improve the quality of fellows going forward.

**Capacity & Feasibility of Recommendation *(on a scale of 1-3)***

- 2 - This could be a program put together through Nevada Heal or through Clark County Medical Society or the equivalent thereof for Washoe County.

**Advances Racial and Health Equity due to Recommendation *(on a scale of 1-3)***

- 2 - Only advances by making the bench deeper for addiction specialists.

**Possible Presenters on this Recommendation**

- Dr Maureen Strohm- Fellowship Director at Southern Hills Addiction Fellowship program
- Dr Brian Kaszuba- Recent graduate of fellowship
- Dr Stephanie Zority-Recent graduate of fellowship